MAXIMUS FEDERAL SERVICES, INC.
Independent Bill Review
P.O. Box 138006
Sacramento, CA 95813-8006
(855) 865-8873 Fax: (916) 605-4280

INDEPENDENT BILLING REVIEW FINAL DETERMINATION

June 12, 2018

[redacted]

IBR Case Number:	CB18-0000495	Date of Injury:	06/19/1989
Claim Number:	[redacted]	Application Received:	05/08/2018
Assignment Date:	05/30/2018		
Claims Administrator:	[redacted]		
Date(s) of service:	02/21/2018 – 02/21/2018		
Provider Name:	[redacted]		
Employee Name:	[redacted]		
Disputed Codes:	93978		

Dear [redacted]:

MAXIMUS Federal Services has completed the Independent Bill Review ("IBR") of the above Workers' Compensation case. This letter provides you with the IBR Final Determination and explains how the determination was made.

Final Determination: OVERTURN. MAXIMUS Federal Services has determined that additional reimbursement is warranted. The Claims Administrator's determination is reversed and the Claim Administrator owes the Provider additional reimbursement of $195.00 for the review cost and $55.37 in additional reimbursement for a total of $250.37. A detailed explanation of the decision is provided later in this letter.

The Claim Administrator is required to reimburse the Provider a total of **$250.37** within 45 days of the date on this letter per section 4603.2 (2a) of the California Labor Code. The determination of MAXIMUS Federal Services and its expert reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties. In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 20 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4603.6(f).

Sincerely,

MAXIMUS

Cc: [redacted]

DOCUMENTS REVIEWED

Pertinent documents reviewed to reach the determination:

- The Independent Bill Review Application
- The original billing itemization
- Supporting documents submitted with the original billing
- Explanation of Review in response to the original bill
- Request for Second Bill Review and documentation
- Supporting documents submitted with the request for second review
- The final explanation of the second review
- AMA CPT
- OMFS/RBRVS
- CCR § 9789.15.6

HOW THE IBR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services Chief Coding Specialist reviewed the case file and researched pertinent coding and billing standards to reach a determination. In some cases a physician reviewer was employed to review the clinical aspects of the care to help make a determination. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services.

ANALYSIS AND FINDING

Based on review of the case file the following is noted:

- **ISSUE IN DISPUTE**: **Provider seeking $55.37 in additional remuneration for 93978 submitted for date of service 02/21/2018.**
- Opportunity to Dispute Eligibility Communicated with the Claims Administrator on 05/11/2018; response not yet received 04/09/2018.
- CMS 1500, Place of Service 11 with the following line items:
    1. ML102
    2. 93000
    3. 93010
    4. 93307
    5. 93320
    6. 93325
    7. **93978**
    8. 36410
- EOR reflect "$226.35" reimbursement for HCPCS 93978 performed on the same date as reimbursed service, ML102 and other Diagnostic Cardiovascular Procedures, based on "Schedule Allowance."
- 93978 services were performed as part of Med-Legal services and are not subject to PPO reduction.
- Code Description 93978: Duplex scan of aorta, inferior vena cava, iliac vasculature, or bypass grafts; complete study.
- RBRVS reflects 93978 with a Multiple Procedure Indicator of "6" and may be subject to Diagnostic Cardiovascular Procedures – Multiple Procedure Reduction based on procedure ranking Cardiovascular Procedure ranking performed on the same day.
- **CCR § 9789.15.6** Diagnostic Cardiovascular Procedures – Multiple Procedure Reduction
  (a) The Multiple Procedure Payment Reduction (MPPR) on diagnostic cardiovascular procedures applies when multiple services are furnished to the same patient on the same day. The MPPR applies to Technical Component (TC)-only services, and to the TC of global services. **Full payment is made for the TC service with the highest payment**. Payment is made at 75 percent for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice, i.e., same Group National Provider Identifier (NPI)) to the same patient on the same day. The MPPR does not apply to professional component (PC) services. See section 9789.19 for the location of the list of codes subject to the MPPR on diagnostic cardiovascular procedures, by date of service.
- Disputed Service, HCPCS 93978 is the TC service with the highest payment of the 6 (six) Diagnostic Cardiovascular Procedure performed on 02/21/2018 and is not subject to a reduction as reflected on the EOR; 93978 Overturned
- **Based on the aforementioned documentation and guidelines, reimbursement is indicated for 93978.**

The table on page 4 below describes the pertinent claim line information.

DETERMINATION OF ISSUE IN DISPUTE: 93978

Date of Service: 01/24/2018							
Physician							
Service Code	**Provider Billed**	**Plan Allowed**	**Dispute Amount**	**Assist Surgeon**	**Units**	**Workers' Comp Allowed Amt.**	**Notes**
93978	$281.73	$226.35	$55.37	N/A	1	$281.72	[284.71 (OMFS)-226.35 (Plan Allowed) 281.72 = 58.36] **$55.37** **Amount in Dispute** Due Provider Refer to Analysis

Copy to:

[redacted]

[redacted]